REQUEST FOR RELEASE OF INFORMATION
TO THE VANCOUVER DISPENSARY SOCIETY

This form has been designed to ensure that confidentiality is a respected right, and to make provisions for the exchange of relevant information between service workers.

Therefore, I,

______________________________________________

Patient's Name

☐ - Physician's statement and/or prescription

☐ - Confirmation of membership

☐ - Confirmation of diagnosis

☐ - Other________________________

be released from_____________________________________________

and forwarded to The Vancouver Dispensary (fax 604-255-1845).

This form is intended for those seeking membership within The Vancouver Dispensary Society.

This consent is valid for one time only, and additional releases of information will require my consent. The person/organization to whom my information is being released is prohibited from further sharing without my written authorization.

PATIENT'S NAME:_________________________________________________

SIGNATURE:______________________________________________________

MEMBERSHIP NUMBER (IF APPLICABLE):___________________________

DATE:____________________________________________________________